Pro Medical East LLC
A GARDEN STATE MEDICAL SUPPLY COMPANY

PHYSICIAN ORDER AND CERTIFYING PHYSICIAN STATEMENT FOR DIABETIC SHOES AND INSERTS

PATIENT INFORMATION

NAME _____ ADDRESS _____ CITY _____ STATE ___ ZIP _____

INSURANCE _____ NUMBER _____ PHONE _____ SEX ___ DOB _____

PHYSICIAN INFORMATION

PHYSICIAN _____ NPI# _____ FAX _____

ADDRESS _____ CITY, STATE, ZIP _____ PHONE _____

APPROVED SERVICES

All information must be filled out completely and reviewed by physician

Required. 1 pair unless otherwise noted

A5500 Extra Depth Diabetic Shoes

Required. Choose One. 3 Pair unless otherwise noted.

Custom Molded Inserts **Heat** Molded Inserts

Optional

L5000 PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER LEFT RIGHT

SECTIONS A & B MUST BE COMPLETED FOR PRESCRIPTION TO BE VALID

SECTION A - PRIMARY DIAGNOSIS

Required. Choose One. DIABETES MELLITUS (Please fill in correct ICD-10 code)

TYPE I		TYPE II		OTHER
W/ DIABETIC NEUROPATHY	E10.40	W/ DIABETIC NEUROPATHY	E11.40	_____
W/O COMPLICATIONS	E10.9	W/O COMPLICATIONS	E11.9	

SECTION B - SECONDARY DIAGNOSIS

Requred. Choose at least 1.

I further determined that the patient has one or more of the following conditions: (Check all that apply and fill in ICD-10 code)

HISTORY OF PREVIOUS FOOT ULCERATION Z86.31

HISTORY OF PRE-ULCERATIVE CALLUS L84

POOR CIRCULATION I87.2

OTHER _____

HISTORY OF PARTIAL OR COMPLETE AMPUTATION OF THE FOOT

FOOT				ANKLE			
LT	Z89.432	RT	Z89.431	LT	Z89.442	RT	Z89.441
GREAT TOE				OTHER TOE(S)			
LT	Z89.412	RT	Z89.411	LT	Z89.422	RT	Z89.421

FOOT DEFORMITY

HAMMERTOES				BUNIONS			
LT	M20.42	RT	M20.41	LT	M20.12	RT	M20.11
HEEL SPURS				OTHER			
LT	M77. 32	RT	M77. 31	_____			

PHYSICIAN SIGNATURE AND PHYSICIAN INFORMATION MUST MATCH FOR PRESCRIPTION TO BE VALID
SIGNATURE STAMPS ARE NOT ACCEPTABLE

I certify that I am treating this patient under a comprehensive plan of care for his/her diabetes. I certify that the information provided is true and correct. I certify that I have thoroughly documented the patient's medical necessity for the product(s) ordered and will provide Pro Medical East with all required supporting documentation.

MD OR DO, PECOS ENROLLED ONLY

PHYSICIAN SIGNATURE _____ DATE _____

PLEASE FAX PRESCRIPTION TO : 603-835-3229

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